MODEL CLAIM FORM FOR SUPERVISED ADMINISTRATION

Claim for month ending:		**Pharmacy stamp**
Name of pharmacy:		
Address:		
Name of prescriber:		
Address:		
PCT locality:		

Client's name	Date of supervision	Quantity and strength dispensed

Total: Fee x number of doses supervised = £

I confirm that this is an accurate record of supervised consumption carried out at the above pharmacy for these patients.

Pharmacist's signature		**Date**	

Please return this form within 3 months of prescription start date to:

(Payment administrator and address)

For any enquiries please contact XXXXXXXXX on XXXXXXX(telephone number)

All of the above details must be fully completed before payment can be made.